

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9278  
CERTIFICATE OF DEATH

Reg. Dist. No. 09270

|   |                               |  |                                   |
|---|-------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Charles</u> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>Charles</u>                     |                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laplata</u>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laplata</u>  |                                   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  |                               | d. STREET ADDRESS  |                                   |
| 3. NAME OF DECEASED<br>(Type or print) First <u>JOSEPH</u> Middle <u>A</u> Last <u>BRADBURN</u>   |                               | 4. DATE OF DEATH Month <u>SEPT</u> Day <u>6</u> Year <u>1956</u>   |                                   |
| 5. SEX <u>MALE</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-25-1898</u> |
| 9. AGE (In years last birthday) <u>57</u> yrs.  |                               | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>ST. MARYS Co</u>  |                                   |
| 11. BIRTHPLACE (State or foreign country) <u>USA</u>  |                               | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |                                   |
| 13. FATHER'S NAME <u>FRANK E BRADBURN</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>CATHERINE M CULLISON</u>   |                                   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)   |                               | 16. SOCIAL SECURITY NO. <u>Joseph F Bradburn</u>   |                                   |
| 17. INFORMANT Address <u>Laplata Md</u>   |                               | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]   |                                   |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>581.1</u> DUE TO <u>cirrhosis of liver</u>   |                               | INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>  |                                   |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>alcohol consumption</u> DUE TO (c)  |                               | <u>50 years</u>  |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac failure - chronic</u>  |                               |  |                                   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |  |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. <u>11</u> p. m. 19 <u>56</u>  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |                                   |
| 21. I certify that I attended the deceased from <u>7-30</u> , 19 <u>56</u> , to <u>9-6</u> , 19 <u>56</u> that I last saw the deceased alive on <u>9-6</u> , 19 <u>56</u> , and that death occurred at <u>8:15 P</u> M, from the causes and on the date stated above. |                               |  |                                   |
| ACTUAL SIGNATURE <u>Fred Johnson</u> M.D.   |                               | ADDRESS (Street, city or town, state) <u>Laplata, md.</u> DATE SIGNED <u>9-6-56</u>  |                                   |
| PHYSICIAN'S NAME (Type) <u>FREDERICK M. JOHNSON</u>   |                               |  |                                   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 22b. DATE THEREOF <u>9-10-56</u>   |                                   |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>  |                               | 22d. LOCATION (City, town, or county) (State) <u>Laplata md</u>  |                                   |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Chehart Inc</u> ADDRESS <u>Laplata md</u>   |                               | 24a. REC'D BY REGISTRAR DATE <u>9/10/56</u>  |                                   |
|   |                               | 24b. REGISTRAR'S SIGNATURE <u>Julia H. Parry</u>   |                                   |

CERTIFICATE OF DEATH

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| NAME OF DECEASED<br>[Faint handwritten name]            |  | SEX<br>[Faint handwritten sex]                        |  | AGE<br>[Faint handwritten age]                          |  |
| DATE OF DEATH<br>[Faint handwritten date]               |  | PLACE OF DEATH<br>[Faint handwritten place]           |  | TIME OF DEATH<br>[Faint handwritten time]               |  |
| CAUSE OF DEATH<br>[Faint handwritten cause]             |  | MANNER OF DEATH<br>[Faint handwritten manner]         |  | PLACE OF INTERMENT<br>[Faint handwritten place]         |  |
| SIGNATURE OF PHYSICIAN<br>[Faint handwritten signature] |  | SIGNATURE OF CORONER<br>[Faint handwritten signature] |  | SIGNATURE OF REGISTRAR<br>[Faint handwritten signature] |  |
| CITY<br>[Faint handwritten city]                        |  | COUNTY<br>[Faint handwritten county]                  |  | STATE<br>[Faint handwritten state]                      |  |

BUREAU V. 2

SEP 13 1956

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09271

9279

Item 9 Filed 10-30-56 at

Reg. Dist. No. 101

|  |                                  |  |   |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>CHARLES</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MD</b> b. COUNTY <b>Charles</b> <b>Ironside</b>                       |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>LAPLATA HOSP LAPLATA MD</b>   |                                  | d. STREET ADDRESS<br><b>Ironside</b>   |   |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><b>ROSIE BROWN Virginia</b>   |                                  | 4. DATE OF DEATH Month Day Year<br><b>9 28 1956</b>  |   |
| 5. SEX<br><b>FEMALE</b>  | 6. COLOR OR RACE<br><b>NEGRO</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                | 8. DATE OF BIRTH<br><b>6-3-96</b> 60 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>MANCHESTER, VA</b>   |   |
| 11. BIRTHPLACE (State or foreign country)  |                                  | 12. CITIZEN OF WHAT COUNTRY?   |   |
| 13. FATHER'S NAME<br><b>D. Pheus</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Anderson</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>None</b>   |   |
| 17. INFORMANT<br><b>DOROTHY B. HARRON</b>  |                                  | Address<br><b>NANJUNORY</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CORONARY ARTERY SCLEROSIS</b><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                  |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. 19  |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .   |                                  |  |   |
| ACTUAL SIGNATURE<br><b>R S Fisher</b>  |                                  | M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/> |   |
| EXAMINER'S NAME (Type)   |                                  | DATE SIGNED<br><b>9-29-56</b>  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 22b. DATE THEREOF<br><b>10/2/56</b>  |   |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Mt Hope</b>   |                                  | 22d. LOCATION (City, town, or county) (State)<br><b>Ironside Md</b>  |   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>John M. Jenkins</b>   |                                  | ADDRESS<br><b>1702-12th St NW</b>  |   |
| 24. REC'D BY REGISTRAR<br><b>DATE 9-29-56</b>  |                                  | 24b. REGISTRAR'S SIGNATURE<br><b>Mary Southland</b>  |   |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

9280

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 100

|   |                                     |   |  |  |  |   |  |
|---|-------------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>CHARLES</b> MARYLAND  |                                     |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>LA PLATA</b>   |                                     | c. LENGTH OF STAY IN 1b<br><b>LIFE</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>LA PLATA</b>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>PHYSICIANS' MEMORIAL HOSPITAL</b>  |                                     |   |  | d. STREET ADDRESS<br><b>WASHINGTON AVENUE</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>"MALE INFANT" CAMPBELL</b>   |                                     |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>SEPTEMBER 9 1956</b>  |  |   |  |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>NEGRO-US</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>SEPTEMBER 9, 1956</b> |  | 9. AGE (In years last birthday)<br><b>— yrs.</b> | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.<br><b>— — 3 —</b>                                   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>INFANT</b>  |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 13. FATHER'S NAME<br><b>LOUIS CAMPBELL</b>  |                                     |   |  | 14. MOTHER'S MAIDEN NAME<br><b>LILLIAN DIXON</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>   |                                     | 16. SOCIAL SECURITY NO.<br><b>—</b>   |  | 17. INFORMANT<br>Address<br><b>LOUIS CAMPBELL; LA PLATA, MD.</b>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASPHYXIA NEONATORUM (HYALINE MEMBRANE DISEASE)</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>762.0</b><br>(c) <b>3 HOURS</b>  |                                     |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 HOURS</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>NO INJURY</b>   |                                     |   |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.<br><b>NONE</b>  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>NO INJURY</b>        |  |  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |                                     | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>               |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>—</b>   |  | 20f. (City or town) (County) (State)<br><b>— — —</b>  |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |                                     |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br><b>John H. Griffin</b> M.D.   |                                     |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
| EXAMINER'S NAME (Type)<br><b>JOHN H. GRIFFIN, M.D.</b>  |                                     |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
|   |                                     |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                     | 22b. DATE THEREOF<br><b>9-10-56</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>—</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>La Plata, Maryland</b>                        |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>1000430XV3</b>   |                                     |   |  | ADDRESS<br><b>—</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>9/11/56</b>  |  |
|   |                                     |   |  |  |  | 24b. REGISTRAR'S SIGNATURE<br><b>John T. Porey</b>  |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH—BALTIMORE 19  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

SEP 13 1956

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09273

9281

## CERTIFICATE OF DEATH

Reg. Dist. No. 106

|  |                                       |   |                         |   |   |  |                                       |
|--|---------------------------------------|---|-------------------------|---|---|--|---------------------------------------|
| <b>1. PLACE OF DEATH</b>   |                                       |   |                         | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>  |   |  |                                       |
| COUNTY <i>Charles</i>  |                                       | STATE <i>MD</i>   |                         | COUNTY <i>Charles</i>   |   |  |                                       |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br><i>Indian Head</i>  |                                       | LENGTH OF STAY (in this place)<br><i>5 yrs</i>  |                         | CITY (If outside corporate limits, write RURAL and give nearest town)<br><i>Indian Head</i> |   |  |                                       |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |                                       | STREET ADDRESS (If rural give location)   |                         |   |   |  |                                       |
| <b>3. NAME OF DECEASED</b><br>(Type or Print) <i>Pearl</i> (First) <i>Edston</i> (Middle) (Last)   |                                       |   |                         | <b>4. DATE OF DEATH</b><br>Sept. 24 1956 (Month) (Day) (Year)                               |   |  |                                       |
| <b>5. SEX</b><br><i>F</i>  | <b>6. COLOR OR RACE</b><br><i>Col</i> | <b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b><br><i>Married</i>                                     | <b>8. DATE OF BIRTH</b> |   | <b>9. AGE last birthday</b><br><i>54</i> yrs. | <b>IF UNDER 1 YEAR</b><br>Months Days                                | <b>IF UNDER 24 HRS.</b><br>Hours Min. |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>   |                                       | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><i>own home</i>   |                         | <b>11. BIRTHPLACE</b> (State or foreign country)<br><i>Pommonoy, Md.</i>                    |   | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><i>U.S.</i>                   |                                       |
| <b>13. FATHER'S NAME</b><br><i>Joseph Brown</i>  |                                       |   |                         | <b>14. MOTHER'S MAIDEN NAME</b><br><i>Marie Montgomery</i>                                  |   |  |                                       |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b><br>(Yes, no, or unk.)  |                                       | <b>16. SOCIAL SECURITY NO.</b>  |                         | <b>17. INFORMANT &amp; ADDRESS</b><br><i>George Easton, Indian Head Md</i>                  |   |  |                                       |
| <b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>   |                                       |   |                         |   |   | <b>INTERVAL BETWEEN ONSET AND DEATH</b>                              |                                       |
| <b>18. MEDICAL CERTIFICATION</b>   |                                       |   |                         |   |   |  |                                       |
| <b>18a. IMMEDIATE CAUSE</b> (A) <i>Coronary Occlusion</i>  |                                       |   |                         |   |   | <i>immediate</i>   |                                       |
| <b>18b. ANTECEDENT CAUSE(S)</b> (B) <i>Hypertensive Heart Disease</i>  |                                       |   |                         |   |   | <i>5 yrs.</i>  |                                       |
| <b>18c. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b> (C) <i>None</i>   |                                       |   |                         |   |   |  |                                       |
| <b>18d. STATING UNDERLYING CAUSE LAST</b>  |                                       |   |                         |   |   |  |                                       |
| <b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>  |                                       |   |                         |   |   |  |                                       |
| <b>19a. DATE OF OPERATION</b>  |                                       | <b>19b. MAJOR FINDINGS OF OPERATION</b>   |                         |   |   |  |                                       |
|  |                                       |   |                         |   |   |  |                                       |
| <b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                       | <b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>                                 |                         | <b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)                         |   |  |                                       |
| <b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)  |                                       | <b>21e. INJURY OCCURRED</b> White at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |                         | <b>21f. HOW DID INJURY OCCUR?</b>   |   |  |                                       |
|  |                                       |   |                         |   |   |  |                                       |
| <b>22. I hereby certify</b> that I attended the deceased from <i>Feb. 2, 1956</i> , to <i>Sept. 24, 1956</i> , that I last saw the deceased alive on <i>Aug. 1, 1956</i> , and that death occurred at <i>1:15 P.M.</i> , from the causes and on the date stated above. |                                       |   |                         |   |   |  |                                       |
| <b>SIGNATURE</b> <i>Frank A. Busman M.D.</i>   |                                       |   |                         | <b>ADDRESS</b> (Street, city, town, state) <i>Indian Head, Md.</i>                          |   | <b>DATE SIGNED</b> <i>9/24/56</i>                                    |                                       |
| <b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Burial</i>  |                                       | <b>DATE THEREOF</b> <i>9/27/56</i>  |                         | <b>NAME OF CEMETERY OR CREMATORY</b> <i>Pommonoy</i>  |   | <b>LOCATION</b> (City, town, or county) (State) <i>Pommonoy, Md.</i> |                                       |
| <b>24. REC'D BY REGISTRAR</b> <i>9/24/56</i>   |                                       | <b>REGISTRAR'S SIGNATURE</b> <i>Odey Price</i>  |                         | <b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Pennett Coler Mason Spring Md</i>                |   |  |                                       |

# CERTIFICATE OF DEATH

0283

NOT FOR FILING

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. DATE OF DEATH

7. PLACE OF DEATH

8. TIME OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESS

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF INTERVIEWER

18. SIGNATURE OF CLERK

19. SIGNATURE OF CHIEF OF BUREAU

20. SIGNATURE OF ASSISTANT CHIEF OF BUREAU

21. SIGNATURE OF DEPUTY CHIEF OF BUREAU

22. SIGNATURE OF SECRETARY

23. SIGNATURE OF ASSISTANT SECRETARY

24. SIGNATURE OF CHIEF OF DIVISION

25. SIGNATURE OF ASSISTANT CHIEF OF DIVISION

26. SIGNATURE OF DEPUTY CHIEF OF DIVISION

27. SIGNATURE OF SECRETARY OF DIVISION

28. SIGNATURE OF ASSISTANT SECRETARY OF DIVISION

29. SIGNATURE OF CHIEF OF BUREAU OF VITAL STATISTICS

30. SIGNATURE OF ASSISTANT CHIEF OF BUREAU OF VITAL STATISTICS

BUREAU V. S.

SEP 28 1956

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RECEIVED



## 9282 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

100

|  |                           |  |                                 |   |  |   |  |
|--|---------------------------|--|---------------------------------|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Charles</u> MARYLAND   |                           |  |                                 | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Charles</u> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>  |                           |  |                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>                                   |  |   |  |
| c. LENGTH OF STAY IN 1b <u>2 hr.</u>   |                           |  |                                 | d. STREET ADDRESS <u>1013 Strauss Ave.</u>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>Phys. Men. Hosp.</u>  |                           |  |                                 | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>MILLIE</u> First <u>ANN</u> Middle <u>GILLILIAN</u> Last  |                           |  |                                 | 4. DATE OF DEATH <u>9</u> Month <u>28</u> Day <u>1956</u> Year  |  |   |  |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-18-35</u> | 9. AGE (In years by birthday) <u>21</u> yrs.  | IF UNDER 1 YEAR<br>Months <u>2</u> Days <u>8</u> |   | IF UNDER 24 HRS.<br>Hours <u>1</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>College</u>   |                                 | 11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |
| 13. FATHER'S NAME <u>Edgar G. Gillilan</u>   |                           |  |                                 | 14. MOTHER'S MAIDEN NAME <u>Grace L. Bowie Gillilan</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>   |                           | 16. SOCIAL SECURITY NO. <u>None</u>  |                                 | 17. INFORMANT Address <u>Mrs. Grace Bowie Gillilan Indian Head, Md.</u>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Proc. base of skull</u><br><u>816X</u> DUE TO <u>Auto accident</u><br>Conditions, if any, which gave rise to immediate cause (b) <u>Auto accident</u><br>(c) <u>Auto accident</u><br>DUE TO <u>Auto accident</u><br>cause last.   |                           |  |                                 | INTERVAL BETWEEN ONSET AND DEATH <u>9-28-56</u><br><u>9-28-56</u>   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                           |  |                                 |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Car accident Passenger</u>                               |                                 |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year <u>9-28</u> 19 <u>56</u><br>Hour <u>7:30</u> a. m. p. m.  |                           | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work  |                                 | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>   |  | 20f. (City or town) <u>Indian Head</u> (County) <u>Charles</u> (State) <u>Md.</u> |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> . |                           |  |                                 |   |  |   |  |
| ACTUAL SIGNATURE <u>E. J. EDELEN</u> M.D.  |                           |  |                                 | DATE SIGNED <u>9-28-56</u>  |  |   |  |
| EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>   |                           |  |                                 | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                           | 22b. DATE THEREOF <u>10-1-56</u>   |                                 | 22c. NAME OF CEMETERY OR CREMATORY <u>St Paul's Cem.</u>  |  | 22d. LOCATION (City, town, or county) (State) <u>Waldorf, Md.</u>                 |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>The Hunt Funeral Home Waldorf, Md.</u>   |                           |  |                                 | 24a. REC'D BY REGISTRAR <u>DATE 3 1956</u>  |  | 24b. REGISTRAR'S SIGNATURE <u>Mr. F. H. P. P.</u>                                 |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

OCT 3 1956

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1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9283

## CERTIFICATE OF DEATH

09275

Reg. Dist. No. 100

|   |                             |  |                  |   |                 |  |                  |
|---|-----------------------------|--|------------------|---|-----------------|--|------------------|
| 1. PLACE OF DEATH   |                             |  |                  | 2. USUAL RESIDENCE (HOME) OF DECEASED                                 |                 |  |                  |
| COUNTY <u>CHARLES</u>   |                             | MARYLAND   |                  | STATE <u>MARYLAND</u> COUNTY <u>CHARLES</u>                           |                 |  |                  |
| CITY (If outside corporate limits, write RURAL and give nearest town)   |                             | LENGTH OF STAY (in this place)   |                  | CITY (If outside corporate limits, write RURAL and give nearest town) |                 |  |                  |
| TOWN <u>HUGHESVILLE</u>   |                             |  |                  | TOWN <u>HUGHESVILLE</u>   |                 |  |                  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS   |                             |  |                  | STREET ADDRESS (If rural give location)                               |                 |  |                  |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)   |                             |  |                  | 4. DATE OF DEATH (Month) (Day) (Year)                                 |                 |  |                  |
| <u>MARY JULIA HAWKINS</u>   |                             |  |                  | <u>SEPTEMBER 5 1956</u>   |                 |  |                  |
| 5. SEX  | 6. COLOR OR RACE            | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)   | 8. DATE OF BIRTH | 9. AGE last birthday yrs.   | IF UNDER 1 YEAR |  | IF UNDER 24 HRS. |
| <u>FEMALE</u>   | <u>COLOR-OR</u>             | <u>MARRIED</u>   | <u>2-13-1892</u> | <u>64</u>   | Months          | Days   | Hours Min.       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                             | 10b. KIND OF BUSINESS OR INDUSTRY  |                  | 11. BIRTHPLACE (State or foreign country)                             |                 | 12. CITIZEN OF WHAT COUNTRY?   |                  |
| <u>HOUSEWIFE</u>  |                             | <u>HOME</u>  |                  | <u>Charles Co.</u>  |                 | <u>USA.</u>  |                  |
| 13. FATHER'S NAME   |                             |  |                  | 14. MOTHER'S MAIDEN NAME  |                 |  |                  |
| <u>Stephen Johnson</u>  |                             |  |                  | <u>Ann Cody</u>   |                 |  |                  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)   |                             | 16. SOCIAL SECURITY NO.  |                  | 17. INFORMANT & ADDRESS   |                 |  |                  |
| <u>NO</u>   |                             | <u>NONE</u>  |                  | <u>Frank Hawkins Bryantown, Md.</u>                                   |                 |  |                  |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  |                             |  |                  |   |                 | INTERVAL BETWEEN ONSET AND DEATH   |                  |
| 18. MEDICAL CERTIFICATION   |                             |  |                  |   |                 |  |                  |
| IMMEDIATE CAUSE (A) <u>CEREBRAL HEMORRHAGE, LEFT</u>  |                             |  |                  |   |                 | <u>18 HOURS</u>  |                  |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>ESSENTIAL HYPERTENSION</u>  |                             |  |                  |   |                 | <u>10 YEARS</u>  |                  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>GENERALIZED ARTERIOSCLEROSIS</u>  |                             |  |                  |   |                 | <u>10 YEARS</u>  |                  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |                             |  |                  |   |                 |  |                  |
| 19a. DATE OF OPERATION  |                             | 19b. MAJOR FINDINGS OF OPERATION   |                  |   |                 |  |                  |
|   |                             |  |                  |   |                 |  |                  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                             | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)                                 |                  | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)          |                 | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)  |                             | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |                  | 21f. HOW DID INJURY OCCUR?  |                 |  |                  |
|   |                             |  |                  |   |                 |  |                  |
| 22. I hereby certify that I attended the deceased from <u>FEBRUARY, 1949</u> , to <u>SEPTEMBER 1956</u> , that I last saw the deceased alive on <u>SEPTEMBER 4, 1956</u> , and that death occurred at <u>10:00 P.M.</u> from the causes and on the date stated above. |                             |  |                  |   |                 |  |                  |
| SIGNATURE   |                             | M.D.   |                  | ADDRESS (Street, city, town, state)                                   |                 | DATE SIGNED  |                  |
| <u>John H. Griffin</u>  |                             | <u>EST</u>   |                  | <u>Hughesville Md.</u>  |                 | <u>9/6/56</u>  |                  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)  | DATE THEREOF                | NAME OF CEMETERY OR CREMATORY  |                  | LOCATION (City, town, or county) (State)                              |                 |  |                  |
| <u>Burial</u>   | <u>9-8-56</u>               | <u>St Mary's Cem.</u>  |                  | <u>Bryantown Md.</u>  |                 |  |                  |
| 24. REC'D BY REGISTRAR  | REGISTRAR'S SIGNATURE       | 25. FUNERAL DIRECTOR'S SIGNATURE   |                  | ADDRESS   |                 |  |                  |
| <u>SEP 10 1956</u>  | <u>Mrs. F. Shells Rosey</u> | <u>The Hunt Funeral Home</u>   |                  | <u>Warders, Md.</u>   |                 |  |                  |

# CERTIFICATE OF DEATH

988

DEPT. OF HEALTH

AT MEDICAL EXAMINATION BY THE DEPARTMENT

STATE OF MARYLAND

|                        |  |                       |  |                      |  |
|------------------------|--|-----------------------|--|----------------------|--|
| NAME OF DECEASED       |  | DATE OF DEATH         |  | PLACE OF DEATH       |  |
| JAMES EARL RAY         |  | APRIL 4, 1968         |  | MEMPHIS, TENNESSEE   |  |
| AGE                    |  | SEX                   |  | RACE                 |  |
| 35                     |  | MALE                  |  | WHITE                |  |
| BIRTH DATE             |  | BIRTH PLACE           |  | CITY                 |  |
| JANUARY 5, 1933        |  | MOBILE, ALABAMA       |  | MEMPHIS, TENNESSEE   |  |
| OCCUPATION             |  | EDUCATION             |  | RELIGION             |  |
| CONTRACTOR             |  | HIGH SCHOOL           |  | METHODIST            |  |
| MARITAL STATUS         |  | CAUSE OF DEATH        |  | MANNER OF DEATH      |  |
| SINGLE                 |  | HEART DISEASE         |  | SUICIDE              |  |
| PREVIOUS ILLNESS       |  | IMMEDIATE CAUSE       |  | FUNDAMENTAL CAUSE    |  |
| NONE                   |  | CORONARY THROMBOSIS   |  | CORONARY THROMBOSIS  |  |
| SIGNATURE OF PHYSICIAN |  | SIGNATURE OF DECEASED |  | SIGNATURE OF WITNESS |  |
| JAMES EARL RAY         |  | JAMES EARL RAY        |  | JAMES EARL RAY       |  |
| DATE                   |  | DATE                  |  | DATE                 |  |
| APRIL 4, 1968          |  | APRIL 4, 1968         |  | APRIL 4, 1968        |  |

RECEIVED  
SEP 10 1966  
BUREAU V. S.

NOTIFICATION OF DEATH TO BE FILED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE DISTRICT OF COLUMBIA  
The following information is being furnished to the Clerk of the District Court of the District of Columbia for the purpose of recording the death and issuing the death certificate.  
Name of Deceased: JAMES EARL RAY  
Date of Death: APRIL 4, 1968  
Place of Death: MEMPHIS, TENNESSEE  
Age: 35  
Sex: MALE  
Race: WHITE  
Birth Date: JANUARY 5, 1933  
Birth Place: MOBILE, ALABAMA  
City: MEMPHIS, TENNESSEE  
Occupation: CONTRACTOR  
Education: HIGH SCHOOL  
Religion: METHODIST  
Marital Status: SINGLE  
Cause of Death: HEART DISEASE  
Manner of Death: SUICIDE  
Immediate Cause: CORONARY THROMBOSIS  
Fundamental Cause: CORONARY THROMBOSIS  
Signature of Physician: JAMES EARL RAY  
Signature of Deceased: JAMES EARL RAY  
Signature of Witness: JAMES EARL RAY  
Date: APRIL 4, 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9284 CERTIFICATE OF DEATH

09276  
100

Reg. Dist. No.

|  |                                      |  |   |
|--|--------------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Charles Co</i> MARYLAND  |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <i>md.</i> b. COUNTY <i>Charles Co</i>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lopata md.</i>   |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lopata md.</i>   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                                      | d. STREET ADDRESS  |   |
| 3. NAME OF DECEASED<br>(Type or print) <i>Mary</i> First <i>DELAI</i> Middle <i>ROSE</i> Last <i>JAMESON</i>   |                                      | 4. DATE OF DEATH <i>Sept 29</i> Month <i>29</i> Day <i>19</i> Year <i>56</i>   |   |
| 5. SEX <i>Female</i>   | 6. COLOR OR RACE <i>White</i>        | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Dec 31, 1902</i> 54 yrs.                    |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>  |                                      | 9b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>   |   |
| 10. BIRTHPLACE (State or foreign country) <i>Maryland</i>  |                                      | 11. CITIZEN OF WHAT COUNTRY? <i>USA</i>  |   |
| 12. FATHER'S NAME <i>William Fairbairn Cooksey</i>   |                                      | 13. MOTHER'S MAIDEN NAME <i>Alice P. Pilkerton</i>   |   |
| 14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>   |                                      | 15. SOCIAL SECURITY NO. <i>170X</i>  |   |
| 16. INFORMATION  |                                      | 17. ADDRESS <i>Jess. Jameson Lopata md.</i>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Metastatic Pneumonia</i><br><i>170X</i> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Adenocarcinoma (g.i.v) of Right Breast</i><br>DUE TO (c) <i>2 nodal Metastases</i> |                                      | INTERVAL BETWEEN ONSET AND DEATH<br><i>2 DAYS</i><br><i>5 3/4 YRS</i>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                      |  |   |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                      |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o. m. 19  |                                      | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                      | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I attended the deceased from <i>Jan 31</i> , 19 <i>51</i> , to <i>Sept 29</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Sept 29</i> , 19 <i>56</i> , and that death occurred at <i>5 P. M.</i> , from the causes and on the date stated above.  |                                      |  |   |
| ACTUAL SIGNATURE <i>J. Parren Jarboe</i> M.D.  |                                      | DATE SIGNED <i>Sept 29, 1956</i>   |   |
| PHYSICIAN'S NAME (Type) <i>J. PARRAN JARBOE, M.D.</i>  |                                      |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>  | 22b. DATE THEREOF <i>Oct 2, 1956</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart</i>   | 22d. LOCATION (City, town, or county) (State) <i>Lopata md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Orhart Funeral Home Inc</i>  |                                      | 24a. REC'D BY REGISTRAR <i>DATE 10/3/56</i>  |   |
| ADDRESS <i>Lopata md.</i>  |                                      | 24b. REGISTRAR'S SIGNATURE <i>Julia H Posey</i>  |   |



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

0034

BUREAU V. 3

OCT 5 1956

RECEIVED

## 9285 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 101

|   |   |  |   |  |                             |  |  |
|---|---|--|---|--|-----------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Charles</u> MARYLAND  |   |  |   | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> |                             |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Person Springs</u>  |   | c. LENGTH OF STAY IN 1b  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Incheon Head md</u>                                    |                             | d. STREET ADDRESS                                  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |   |  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                             |  |  |
| 3. NAME OF DECEASED (Type or print) <u>LILLIAN First Middle Last</u> <u>ALBERTA JONES</u>   |   |  |   | 4. DATE OF DEATH Month <u>9</u> Day <u>28</u> Year <u>1956</u>   |                             |  |  |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>C</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 16, 1916</u>      | 9. AGE (In years last birthday) <u>40</u> yrs.   | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.                        |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>Naval Powder Factory</u>  |   | 11. BIRTHPLACE (State or foreign country) <u>Charles Co md.</u>  |                             | 12. CITIZEN OF WHAT COUNTRY?                       |  |
| 13. FATHER'S NAME <u>Augustus Neiss</u>   |   |  |   | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Proctor</u>  |                             |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |   | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT Address  |                             |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Crushed chest on fire truck</u><br>816X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>Auto accident</u><br>(c) <u>9-28-56</u>  |   |  |   |  |                             |  | INTERVAL BETWEEN ONSET AND DEATH, <u>30 min.</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |  |   |  |                             |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>2 car collision - Driver</u>                             |   |  |                             |  |  |
| 20c. TIME OF INJURY Month, Day, Year <u>9-28-56</u> <u>9:00 a.m.</u>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>  | 20f. (City or town) <u>Person Springs</u> | (County) <u>Charles</u>  | (State) <u>md.</u>          |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |   |  |   |  |                             |  |  |
| ACTUAL SIGNATURE <u>E. J. EDELIN</u> M.D.   |   |  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |                             |  |  |
| EXAMINER'S NAME (Type) <u>E. J. EDELIN M.D.</u>   |   |  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |                             |  |  |
|   |   |  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |                             |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 22b. DATE THEREOF <u>10-5-56</u>  | 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Baptist</u>   |   | 22d. LOCATION (City, town, or county) <u>Hill Top</u>  |                             | (State) <u>md.</u>                                 |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Johnson &amp; Jenkins</u> ADDRESS <u>1702 12th St NW Washington DC.</u>   |   |  |   | 24a. REC'D BY REGISTRAR <u>10/1/56</u>   |                             | 24b. REGISTRAR'S SIGNATURE <u>Mary Duellstrand</u> |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V.

RECEIVED

Mr. J. W. Smith

**[LOCAL EXAMINER:]** This certificate should be executed within 24 hours after death. If any delay occurs, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director; give Page 4 to the registrar; retain Page 5 until you are notified by the Registrar's Office. File pages 1 and 2 with the registrar prior to burial.

1

...sory, please ex-  
Page 4 should be  
...cremation,

## 9286 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 4, 11, Film G201 9-20-56 et

Reg. Dist. No.

100

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Charles</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) <input checked="" type="checkbox"/><br>a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington, DC.</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Benedict</b>   |  |   |  | c. LENGTH OF STAY IN 1b  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |  |   |  | d. STREET ADDRESS<br><b>1717 Mass. Ave NW.</b>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>John</b> Middle <b>Joseph</b> Last <b>Leonard</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>September</b> Day <b>13</b> Year <b>1956</b>  |  |   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Aug. 1, 1898</b>                | 9. AGE (in years last birthday)<br><b>58</b> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min.  | IF UNDER 24 HRS.<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>New Jersey</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>US.</b> |   |  |
| 13. FATHER'S NAME<br><b>Joseph Leonard</b>  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>             |  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br>(If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>Address   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>924.8 DUE TO</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Drowning</b><br>DUE TO (c)  |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>9-9-56</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Potomac River</b>  |  |  |  |   |  |
| 20c. TIME OF INJURY<br>Hour a. m. p. m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Choo. Md.</b>  |  | 20f. (City or town) (County) (State)   |  |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE<br><b>E. J. EDELEN</b>   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  | DATE SIGNED<br><b>9-13-56</b>  |  |   |  |
| EXAMINER'S NAME (Type)<br><b>E. J. EDELEN M.D.</b>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   |  |
| 22a. POTENTIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>9/14/56</b>  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b>   |  | 22d. LOCATION (City, town, or County) (State)<br><b>Seaford Md.</b>  |  |   |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>J. W. Lee's Sons - Wink</b>  |  | ADDRESS<br><b>1818 18th St NW</b>   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>18 1956</b>   |  |   |  |
|   |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Mrs. Julia Posey</b>  |  |   |  |

MEDICAL CERTIFICATION

RECEIVED

SEP 18 1956



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9287 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09279

Reg. Dist. No. 100

|  |   |  |   |  |   |  |  |
|--|---|--|---|--|---|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Charles</u> <span style="float: right;">MARYLAND</span>   |   |  |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution; Residence before admission)<br>a. STATE <u>Virginia</u> <span style="float: right;">b. COUNTY <u>Louisiana</u></span> |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Newburg</u>   |   |  | c. LENGTH OF STAY IN 1b<br><br>               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>83x-3</u>   |   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><br>   |   |  |   | d. STREET ADDRESS<br><br>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <u>FOREST CLEMAN THACKER</u>  |   |  |   | <b>4. DATE OF DEATH</b>  |   | Month <u>9</u> Day <u>7</u> Year <u>1956</u>   |  |
| <b>5. SEX</b><br><u>MALE</u>   | <b>6. COLOR OR RACE</b><br><u>WHITE</u> | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                     | <b>8. DATE OF BIRTH</b><br><u>Feb 9, 1908</u> | <b>9. AGE</b> (In years last birthday)<br><u>48</u> yrs.   | <b>IF UNDER 1 YEAR</b><br>Months <u>  </u> Days <u>  </u> | <b>IF UNDER 24 HRS.</b><br>Hours <u>  </u> Min. <u>  </u>                              |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Lumberman</u>   |   | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Lumber Business</u>   |   | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>Virginia</u>  |   | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>                                   |  |
| <b>13. FATHER'S NAME</b><br><u>Newton C Thacker</u>  |   |  |   | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Minnie Austin</u>  |   |  |  |
| <b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)  |   | <b>16. SOCIAL SECURITY NO.</b>   |   | <b>17. INFORMANT</b>   |   | Address <u>Washington DC</u>   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u><br>DUE TO (c) <u>  </u>  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>9-7-56</u>                                      |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  |   |  |   |  |  |
| <b>20a. EXTERNAL CAUSE WAS</b> PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |   |  |   | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  |   |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>   |   | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |   | <b>20f. (City or town)</b> (County) (State)  |  |
| <b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . |   |  |   |  |   |  |  |
| <b>ACTUAL SIGNATURE</b> <u>E. J. Edelen</u> M.D.   |   |  |   | <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>   |   |  |  |
| <b>EXAMINER'S NAME</b> (Type) <u>E. J. EDELEN M.D.</u>   |   |  |   | <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>   |   |  |  |
| <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>   |   |  |   | <b>DATE SIGNED</b> <u>9-8-56</u>   |   |  |  |
| <b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>  |   | <b>22b. DATE THEREOF</b><br><u>Sept 10, 56</u>   |   | <b>22c. NAME OF CEMETERY OR CREMATORY</b><br><u>Louisiana Va</u>   |   | <b>22d. LOCATION</b> (City, town, or county) (State)<br><u>Louisiana Va</u>            |  |
| <b>23. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Archart Inc La Plata Md</u>  |   |  |   | <b>24a. REC'D BY REGISTRAR</b><br>DATE <u>9/10/56</u>  |   | <b>24b. REGISTRAR'S SIGNATURE</b><br><u>Julia H. Passey</u>                            |  |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

SEP 13 1956

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

9288

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Charles</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <u>MD</u> b. COUNTY <u>Charles</u>                     |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laplace</u>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laplace</u>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION   |                                  | d. STREET ADDRESS  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>MARY</u> Middle <u>ALICE</u> Last <u>YATES</u>   |                                  | 4. DATE OF DEATH<br>Month <u>Feb</u> Day <u>11</u> Year <u>1956</u>  |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>Col</u>      | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 11 1880</u>   |
| 9. AGE (In years last birthday) <u>76</u> yrs.   |                                  | 10. AGE (In years last birthday) <u>76</u> yrs.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>W</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (State or foreign country) <u>Charles Co</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME <u>Murphy</u>  |                                  | 14. MOTHER'S MAIDEN NAME <u>Mollie Williams</u>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.  |  |
| 17. INFORMANT <u>Margaret Green</u>  |                                  | Address <u>D.C.</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral occlusion</u><br><u>420.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u><br>DUE TO (c) <u>Senile arteriosclerosis</u> |                                  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>10 yrs</u><br><u>3 years</u><br><u>10 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. <u>5</u> p. m. 19  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>                                  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.  |                                  |  |  |
| ACTUAL SIGNATURE <u>Dr. Wooddy</u>   |                                  | ADDRESS (Street, city or town, state) <u>Jarwood Clinic LA PLATA</u>   |  |
| M.D. <u>MD</u>   |                                  | DATE SIGNED <u>88 Sep 6</u>  |  |
| PHYSICIAN'S NAME (Type) <u>ARTHUR O. WOODY</u>   |                                  | STATE <u>MARYLAND</u>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  | 22b. DATE THEREOF <u>9/10/56</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Holy Ghost</u>   | 22d. LOCATION (City, town, or county) (State) <u>2 issue MD</u>                        |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Rehob Inc</u>  |                                  | ADDRESS <u>Laplace</u>   |  |
| 24a. REC'D BY REGISTRAR <u>Julia H. Passey</u>   |                                  | 24b. REGISTRAR'S SIGNATURE <u>Julia H. Passey</u>  |  |
| DATE <u>9/10/56</u>  |                                  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2028

|                               |  |                               |  |                               |  |
|-------------------------------|--|-------------------------------|--|-------------------------------|--|
| 1. NAME OF DECEASED           |  | 2. SEX                        |  | 3. AGE                        |  |
| 4. DATE OF DEATH              |  | 5. TIME OF DEATH              |  | 6. PLACE OF DEATH             |  |
| 7. CAUSE OF DEATH             |  | 8. MANNER OF DEATH            |  | 9. SIGNATURE OF PHYSICIAN     |  |
| 10. SIGNATURE OF REGISTRAR    |  | 11. SIGNATURE OF WITNESSES    |  | 12. SIGNATURE OF DECEASED     |  |
| 13. SIGNATURE OF FUNERAL HOME |  | 14. SIGNATURE OF BURIAL PLACE |  | 15. SIGNATURE OF INTERVIEWER  |  |
| 16. SIGNATURE OF INTERVIEWER  |  | 17. SIGNATURE OF INTERVIEWER  |  | 18. SIGNATURE OF INTERVIEWER  |  |
| 19. SIGNATURE OF INTERVIEWER  |  | 20. SIGNATURE OF INTERVIEWER  |  | 21. SIGNATURE OF INTERVIEWER  |  |
| 22. SIGNATURE OF INTERVIEWER  |  | 23. SIGNATURE OF INTERVIEWER  |  | 24. SIGNATURE OF INTERVIEWER  |  |
| 25. SIGNATURE OF INTERVIEWER  |  | 26. SIGNATURE OF INTERVIEWER  |  | 27. SIGNATURE OF INTERVIEWER  |  |
| 28. SIGNATURE OF INTERVIEWER  |  | 29. SIGNATURE OF INTERVIEWER  |  | 30. SIGNATURE OF INTERVIEWER  |  |
| 31. SIGNATURE OF INTERVIEWER  |  | 32. SIGNATURE OF INTERVIEWER  |  | 33. SIGNATURE OF INTERVIEWER  |  |
| 34. SIGNATURE OF INTERVIEWER  |  | 35. SIGNATURE OF INTERVIEWER  |  | 36. SIGNATURE OF INTERVIEWER  |  |
| 37. SIGNATURE OF INTERVIEWER  |  | 38. SIGNATURE OF INTERVIEWER  |  | 39. SIGNATURE OF INTERVIEWER  |  |
| 40. SIGNATURE OF INTERVIEWER  |  | 41. SIGNATURE OF INTERVIEWER  |  | 42. SIGNATURE OF INTERVIEWER  |  |
| 43. SIGNATURE OF INTERVIEWER  |  | 44. SIGNATURE OF INTERVIEWER  |  | 45. SIGNATURE OF INTERVIEWER  |  |
| 46. SIGNATURE OF INTERVIEWER  |  | 47. SIGNATURE OF INTERVIEWER  |  | 48. SIGNATURE OF INTERVIEWER  |  |
| 49. SIGNATURE OF INTERVIEWER  |  | 50. SIGNATURE OF INTERVIEWER  |  | 51. SIGNATURE OF INTERVIEWER  |  |
| 52. SIGNATURE OF INTERVIEWER  |  | 53. SIGNATURE OF INTERVIEWER  |  | 54. SIGNATURE OF INTERVIEWER  |  |
| 55. SIGNATURE OF INTERVIEWER  |  | 56. SIGNATURE OF INTERVIEWER  |  | 57. SIGNATURE OF INTERVIEWER  |  |
| 58. SIGNATURE OF INTERVIEWER  |  | 59. SIGNATURE OF INTERVIEWER  |  | 60. SIGNATURE OF INTERVIEWER  |  |
| 61. SIGNATURE OF INTERVIEWER  |  | 62. SIGNATURE OF INTERVIEWER  |  | 63. SIGNATURE OF INTERVIEWER  |  |
| 64. SIGNATURE OF INTERVIEWER  |  | 65. SIGNATURE OF INTERVIEWER  |  | 66. SIGNATURE OF INTERVIEWER  |  |
| 67. SIGNATURE OF INTERVIEWER  |  | 68. SIGNATURE OF INTERVIEWER  |  | 69. SIGNATURE OF INTERVIEWER  |  |
| 70. SIGNATURE OF INTERVIEWER  |  | 71. SIGNATURE OF INTERVIEWER  |  | 72. SIGNATURE OF INTERVIEWER  |  |
| 73. SIGNATURE OF INTERVIEWER  |  | 74. SIGNATURE OF INTERVIEWER  |  | 75. SIGNATURE OF INTERVIEWER  |  |
| 76. SIGNATURE OF INTERVIEWER  |  | 77. SIGNATURE OF INTERVIEWER  |  | 78. SIGNATURE OF INTERVIEWER  |  |
| 79. SIGNATURE OF INTERVIEWER  |  | 80. SIGNATURE OF INTERVIEWER  |  | 81. SIGNATURE OF INTERVIEWER  |  |
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